STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Re-survey.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to recognize and address pain issues for 1 of 1 residents sampled for pain. (#109) Findings included: - Resident #109's Physician Order Sheet (POS) dated 4/4/12 listed diagnoses that included a history of bilateral lower extremity deep vein thrombosis, essential thrombocytosis and hypothyroidism. The History and Physical dated 3/2/12 listed the additional diagnoses of dementia, degenerative joint disease and thrombocytopenia. The admission Minimum Data Set (MDS) 3.0 with	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	04/24/2012

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F 309	Continued From page 1	F 309		

an Assessment Reference Date (ARD) of 4/9/12 identified the resident with a Brief Interview for Mental Status score of 2 that indicated severe cognitive impairment. The MDS noted the resident required extensive assistance of 1 staff for transfer, locomotion on and off the unit, dressing, toilet use and personal hygiene, and required limited assistance of 1 staff for bed mobility and the resident was independent for eating. The MDS noted staff did not give the resident pain medication in the previous 5 days and staff did not complete a formal pain assessment.

The facility lacked a pain Care Area Assessment (CAA).

The admission Skilled nursing Health and Service Evaluation/Assessment dated 4/2/12 recorded the resident had pain in his/her bones and non-verbal signs and symptoms of pain was grimacing on the resident's face.

The pain care plan dated 4/2/12 recorded the resident did not usually have pain, he/she experienced pain during transfers and therapy, and had Tylenol as needed for pain. Staff should notify the licensed nurse when they noticed grimacing or other signs of pain, offer the non-medicinal [pain interventions] including range of motion, repositioning, toileting, dimming lights and to decrease stimuli prior to medicating.

Observation on 4/19/12 at 8:13 A.M. revealed direct care staff C assisted the resident with dressing, transfers and personal hygiene. When direct care staff C put on the resident's shoes, the resident said, "Ouch that hurts," 2 times and

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	175499	A. BUILDING _____ B. WING _____	04/24/2012

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BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 309	Continued From page 2	F 309		

direct care staff C replied he/she was sorry. Direct care staff C assisted the resident to sit at the side of the bed, and the resident stated it hurt and rubbed his/her left knee. Direct care staff C transferred the resident to his/her wheelchair and the resident said, "Oh, ow, oh, oh," Direct care staff C moved the resident's wheelchair to the bathroom and instructed the resident to stand at the grab bar and assisted the resident to stand. When the resident transferred to the standing position, he/she said, "Ow, oh, oh." Direct care staff C did not stop care and report to the licensed nurse when the resident complained of pain.

During an interview on 4/19/12 at 12:58 P.M., administrative nursing staff A stated he/she expected direct care staff to stop care when a resident complained of pain or said, "Ow" and report it to the nurse who should assess the resident's pain.

During an interview on 4/19/12 at 1:44 P.M. direct care staff C stated he/she assisted the resident with range of motion exercises but the resident was on the hospice program and he/she did not want to exercise very often. Direct care staff C stated the resident never complained of pain but acknowledged the resident complained of pain that morning during care. Direct care staff C stated the resident had skin tears on his/her legs which hurt when staff put on the resident's pants, and that was why the resident said, "Ouch," but acknowledged he/she did not ask the resident where the pain was and did not report it to the licensed nurse. Staff C stated the resident always complained when staff assisted him/her putting on the shoes because the shoes were too hard,

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	175499	A. BUILDING _____ B. WING _____	04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 309	Continued From page 3	F 309		

and the resident did not have any other shoes. Staff C stated he/she reported the shoe problem to "several different people, but I cannot remember who."

During an interview on 4/19/12 at 4:11 P.M., direct care staff D stated the resident did not complain of pain, but made faces when staff transferred him/her and told direct care staff D he/she might faint if staff moved him/her.

Review of the Medication Administration Record (MAR) dated 4/5/12 recorded the order for Tylenol 650 milligrams (mg.), every 6 hours as needed. Staff noted they gave the resident Tylenol on 4/11/12, but the MAR lacked documentation for the resident's pain level before they gave the medication and lacked documentation for the resident's response of the effectiveness of the pain medication.

Review of the Treatment Administration Record (TAR) dated 4/5/12 recorded, "Assess pain level every shift and as needed, use 1-10 pain scale, [facial pain] scale or resident observable signs or symptoms of pain. [Minus sign means] no pain, [plus sign means] pain with intervention required until the resident has tolerable pain level." The TAR noted the resident had pain on 4/9/12, 4/10/12, 4/11/12 on the day shift and 4/22/12 on the night shift. On the back of the TAR, staff recorded for 4/9/12 and 4/11/12, "Complains of pain during application of steri strips." The TAR lacked documentation staff implemented any interventions for the resident's pain, or any effectiveness of pain medication given.

The interdisciplinary notes from nursing dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	04/24/2012

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BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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F 309	Continued From page 4 4/2/12 (untimed), 4/11/12 at 7:45 P.M., 4/13/12 at 6:45 P.M., 4/13/12 at 7:50 P.M., 4/14/12 at 2:45 P.M., 4/17/12 (untimed), 4/18/12 (untimed) and 4/20/12 at 12:10 P.M. lacked documentation staff assessed the resident's pain. The nursing notes lacked documentation staff assessed and responded to the resident's pain on the TAR dates for 4/9/12, 4/10/12, 4/11/12 and 4/22/12. During an interview on 4/19/12 at 1:26 P.M., licensed staff B stated licensed staff asked the resident each shift if he/she had pain and record the response on the TAR or in the nursing note. If the resident had pain, the nurse should assess the pain and determine an intervention and the result and effectiveness of the intervention. Licensed staff B stated when a resident complained of pain or said "Ow" or "Ouch", staff should stop care and immediately report it to the nurse who should assess the resident's pain. During the findings meeting on 4/23/12 at approximately 5:21 P.M., administrative nursing staff A acknowledged staff did not record the resident's pain assessment and interventions for the dates in the TAR. The facility provided the policy entitled Pain Assessment and Management dated 2001 which directed staff to observe the resident during rest and movement for physiologic and behavioral (non-verbal) signs of pain, possible signs of pain included verbal expressions such as groaning, crying, screaming and included facial expressions such as grimacing, frowning, clenching of the jaw, limitations in his/her level of activity due to the presence of pain and guarding, rubbing or	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 5 favoring a particular part of the body. Ask the resident if he/she was experiencing pain. Pain management interventions shall reflect the sources, type and severity of pain, address the underlying causes of the resident's pain and re-assess and monitor the resident's response to interventions and level of comfort over time. The facility failed to recognize and address pain issues for this resident who exhibited verbal and non-verbal signs of pain.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to assist in completion of oral care for 1 of 4 residents sampled for activities of daily living. (#109) Findings included: - Resident #109's Physician Order Sheet (POS) dated 4/4/12 listed diagnoses that included a history of bilateral lower extremity deep vein thrombosis, essential thrombocytosis and	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 6	F 312		

hypothyroidism. The History and Physical dated 3/2/12 listed the additional diagnoses of dementia, degenerative joint disease and thrombocytopenia.

The admission Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 4/9/12 identified the resident with a Brief Interview for Mental Status score of 2 that indicated severe cognitive impairment. The MDS noted the resident required extensive assistance of 1 staff for transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene, and required limited assistance of 1 staff for bed mobility and the resident was independent for eating. No oral/dental problems care noted.

The facility lacked a Care Area Assessment (CAA) for dental/oral concerns.

The grooming care plan dated 4/2/12 directed staff to assist with A.M. and P.M. cares and updated 4/19/12, the resident required extensive assistance to remove his/her partial denture at night.

The admission Skilled Nursing Health and Service Evaluation/Assessment dated 4/2/12 recorded the resident required extensive assistance for grooming/hygiene.

The dining/nutritional/oral admission care plan dated 4/2/12 directed the resident on a pureed diet with honey thick liquids, staff should place food right in front of the resident and cue constantly because of poor vision, and the resident was able to feed himself/herself.

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	175499	A. BUILDING _____ B. WING _____	04/24/2012

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F 312	Continued From page 7 The direct care staff care plan book had the notice, "Hey You Guys! Oral care before breakfast, after dinner, brush teeth and mouth, scrub dentures and soak with cleanser DO IT!", dated April 2012. Observation on 4/19/12 at 8:13 A.M., revealed direct care staff C assisted the resident with personal hygiene, placed toothpaste on the resident's toothbrush and handed it to the resident and directed the resident to brush his/her teeth. The resident stated he/she had a partial, and pushed it out of his/her mouth, and direct care staff brushed it. The resident brushed his/her bottom front teeth for 3 seconds and handed the toothbrush back to direct care staff C who took it and directed the resident to rinse his/her mouth. Direct care staff C did not complete the resident's mouth care. 4/19/12 12:58 P.M. administrative nursing staff A stated direct care staff should allow and cue the resident to do oral care as much as possible by themselves, and then direct care staff should complete it if the resident was unable to do so. During an interview on 4/19/12 at 1:26 P.M. licensed staff B stated he/she monitored the direct care staff to complete resident's care needs, reminded staff to complete oral care but did not watch staff do oral care for this resident. During an interview on 4/19/12 at 1:44 P.M., direct care staff C stated staff had to complete oral care for the resident, he/she did not know the resident had a partial bridge and never took it out	F 312		

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	175499	A. BUILDING _____ B. WING _____	04/24/2012

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F 312	Continued From page 8 before today. During an interview on 4/19/12 at 4:11 P.M., direct care staff D stated the resident tried to do some of his/her teeth brushing but staff had to complete the teeth brushing for the resident because he/she was unable to complete it. The facility provided the policy entitled Mouth Care dated 2001 which directed, the purpose of the procedure were to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent infections of the mouth. Allow the resident who is able to provide his/her own mouth care to do so, complete the mouth care according to the procedure and notify the supervisor if the resident refused the mouth care. The facility failed to assist this resident with completion of oral care.	F 312		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	04/24/2012

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F 425	Continued From page 9	F 425		

the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents and the sample included 12 residents. Based on observation, record review and interview, the facility failed to provide medications as ordered by the physician for 1 of 10 residents sampled for medication review (#112).

Findings included:

- Diagnoses listed on the April 2012 Physician's Order Sheet (POS) for resident #112 included rectal prolapsed, urinary tract infection, hypertension, hyponatremia, history of stroke, dyslipidemia, central tremor and osteoporosis. The POS recorded orders on 4-11-12 for metamucil one pack in 8 ounces of liquid daily for bowel management and on 4-12-12 an order for urelle (urinary tract analgesic) one tablet daily.

The care plan dated 4-9-12 directed staff to administer all medications.

Review of the April 2012 Medication Administration Record (MAR) on 4-19-12 at 4:10 P.M. revealed urelle circled 3 times during the month and metamucil circled 6 times during the

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	175499	A. BUILDING _____ B. WING _____	04/24/2012

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F 425	Continued From page 10 month without explanation on the back of the MAR as to why the resident did not receive the medication. The facility-provided policy did not address following physician's orders for medication administration. Observation on 4-18-12 at 2:12 P.M. revealed the resident sat in his/her private room in his/her wheelchair watching TV. During an interview on 4-19-12 at 4:10 P.M., administrative nursing staff A acknowledged the multiple initialed and circled areas on the MAR for his/her Metamucil and urelle and stated if staff did not give a medication, they should circle it on the front of the MAR and write on the back why it was not given. Administrative nursing staff A acknowledged the circled areas and lacked an explanation for why the resident did not receive these medications as ordered. The facility failed to provide this resident with his/her medications as ordered.	F 425		